# EQUALITY IMPACT ASSESSMENT (EIA) Appendix D

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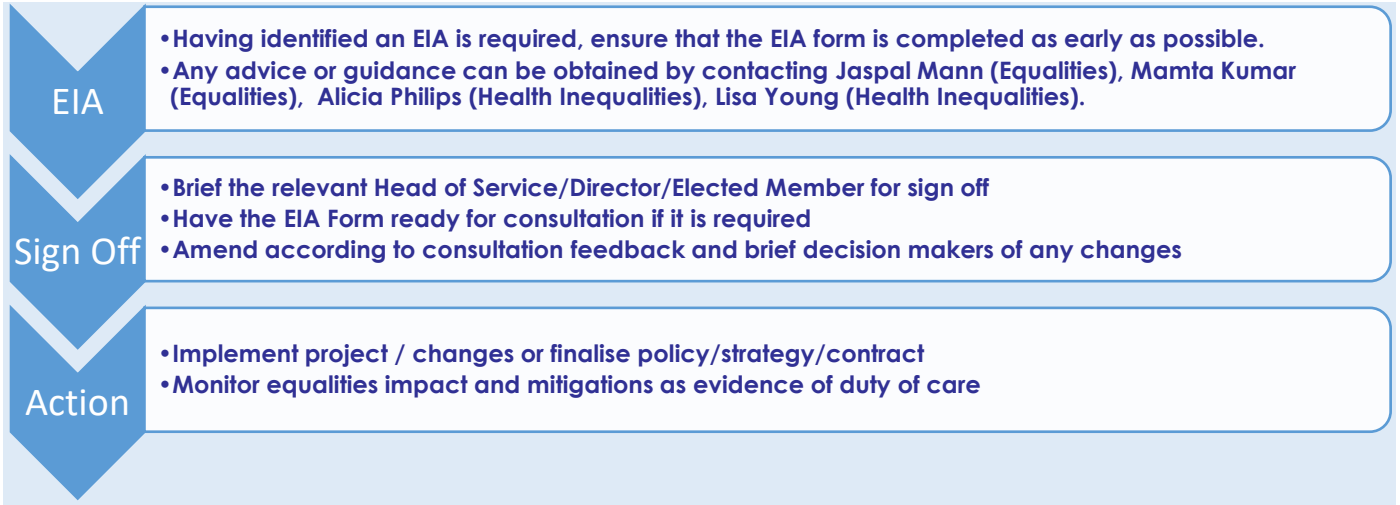
| **Title of EIA** | | **Homelessness and Rough Sleeping Strategy** |
| **EIA Author** | Name | **Sophie Hall** |
| | Position | **Housing and Homelessness Commissioning and Partnerships Lead** |
| | Date of completion | **18/07/2024** |
| **Head of Service** | Name | **Jim Crawshaw** |
| | Position | **Head of Housing and Homelessness** |
| **Cabinet Member** | Name | **Cllr David Welsh** |
| | Portfolio | **Housing & Communities** |




**PLEASE REFER TO EIA GUIDANCE FOR ADVICE ON COMPLETING THIS FORM**

## SECTION 1 – Context & Background

1.1 Please tick one of the following options:

This EIA is being carried out on:

x☐New policy / strategy
☐New service
Review of policy / strategy
☐Review of service
Commissioning

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☐Other project *(please give details)*

1.2 In summary, what is the background to this EIA?

The council has a statutory duty to carry out a periodic review of homelessness in their area and to publish a Homelessness Strategy.
The current Housing and Homelessness Strategy was published in 2019 and runs until 2024. It is aimed at providing a high-level plan to set out the main priorities for the Council and its partners for the life of the strategy, to guide the allocation of resources and investment, and provide a framework to inform project development, to achieve the vision that:
• Coventry Citizens will be able to access a suitable, affordable, and decent home, with the support they need to sustain their housing.
In 2019 when the new strategy was developed the previous Homelessness Strategy and Housing Strategy were combined into one document, this was done as it was recognised that activities to prevent homelessness were to a degree dependent on the availability of permanent housing.

Coventry published its first Rough Sleeping Strategy in December 2019, in line with a requirement by the Government for all areas to have a strategy to prevent and tackle rough sleeping. From the outset it was accepted that the successful delivery of the Rough Sleeping Strategy and Action Plan was not in the Council's power alone. Therefore, a One Coventry partnership approach was crucial to ensure successful realisation of our vision, the strategy needed to be owned, supported, and delivered by ensuring effective collaboration and partnership working.
The Rough Sleeping Strategy and its Action Plan were reflective of and intrinsically linked to the Council's Housing and Homelessness Strategy. The two strategies needed to be considered and delivered in tandem.

It has been decided that we will be separating back out the Housing element of the Housing and Homelessness strategy and we will instead have a combined Homelessness and Rough Sleeping Strategy. This will focus on the positive pathway model and will consider interventions, services, challenges and accommodation provision for people who are homeless or threatened with homelessness.
The homelessness review that has been undertaken and will be the basis of the new Homelessness and Rough Sleeping Strategy and will help us identify actions and priority areas for the next 5 years.

1.3 Who are the main stakeholders involved? Who will be affected?

People who are homeless or at risk of rough sleeping/currently rough sleeping
People who require support and assistance to maintain a tenancy or independent living
Households at risk of losing their current accommodation
Coventry City Council's Housing and Homelessness Service
Homelessness organisations and charities operating in Coventry including supported accommodation providers
Advice agencies operating in Coventry
Registered Providers (Housing Associations)

Private Landlords

1.4 Who will be responsible for implementing the findings of this EIA?

Sophie Hall- Housing & Homelessness Commissioning and Partnerships Lead

## SECTION 2 – Consideration of Impact

*Refer to guidance note for more detailed advice on completing this section.*

In order to ensure that we do not discriminate in the way our activities are designed, developed and delivered, we must look at our duty to:

- Eliminate discrimination, harassment, victimisation and any other conflict that is prohibited by the Equality Act 2010
- Advance equality of opportunity between two persons who share a relevant protected characteristic and those who do not
- Foster good relations between persons who share a relevant protected characteristic and those who do not

2.1 Baseline data and information

Please include a summary of data analysis below, using both your own service level management information and also drawing comparisons with local data where necessary (go to https://www.coventry.gov.uk/factsaboutcoventry)

Homeless review 2024

2.2 On the basis of evidence, complete the table below to show what the potential impact is for each of the protected groups.

- Positive impact (P),
- Negative impact (N)
- Both positive and negative impacts (PN)

- No impact (NI)
- Insufficient data (ID)

**Any impact on the Council workforce should be included under question 2.6 – **not below***

| **Protected Characteristic** | **Impact type** P, N, PN, NI | **Nature of impact and any mitigations required** |
|---|---|---|
| Age 0-18 | **p** | Support for individuals and households who are homeless, at risk of becoming homeless and those rough sleeping or at risk of rough sleeping in this age group |
| Age 19-64 | **P** | Support for individuals and households who are homeless, at risk of becoming homeless and those rough sleeping or at risk of rough sleeping in this age group |
| Age 65+ | **P** | Support for individuals and households who are homeless, at risk of becoming homeless and those rough sleeping or at risk of rough sleeping in this age group |
| Disability | **P** | Support for individuals and households who are homeless, at risk of becoming homeless and those rough sleeping or at risk of rough sleeping with a disability |
| Gender reassignment | **P** | Support for individuals and households who are homeless, at risk of becoming homeless and those rough sleeping or at risk of rough who have undergone gender reassignment |
| Marriage and Civil Partnership | **p** | Support for individuals and households who are homeless, at risk of becoming homeless and those rough sleeping or at risk of rough sleeping who are married or in a civil partnership |
| Pregnancy and maternity | **p** | Support for individuals and households who are homeless, at risk of becoming homeless and those rough sleeping or at risk of rough sleeping who may be pregnant |
| Race (Including: colour, nationality, citizenship ethnic or national origins) | **p** | Support for individuals and households who are homeless, at risk of becoming homeless and those rough sleeping regardless of colour, nationality, citizenship ethnic or national origins |
| Religion and belief | **p** | Support for individuals and households who are homeless, at risk of becoming homeless and those rough sleeping regardless of religion or belief |
| Sex | **p** | Support for individuals and households who are homeless, at risk of becoming homeless and those rough sleeping regardless of sex |

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| Sexual orientation | **p** | Support for individuals and households who are homeless, at risk of becoming homeless and those rough sleeping regardless of sexual orientation |

## HEALTH INEQUALITIES

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| **2.3** | Health inequalities (HI) are unjust differences in health and wellbeing between different groups of people which arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and result in stark differences in how long we live and how many years we live in good health.<br><br>Many issues can have an impact: income, unemployment, work conditions, education and skills, our living situation, individual characteristics and experiences, such as age, gender, disability and ethnicity<br><br>A wide range of services can make a difference to reducing health inequalities. Whether you work with children and young people, design roads or infrastructure, support people into employment or deal with welfare benefits – policy decisions and strategies can help to reduce health inequalities<br><br>**Please answer the questions below to help identify if the area of work will have any impact on health inequalities, positive or negative.**<br><br>**If you need assistance in completing this section please contact: Alicia Philips or Lisa Young in Public Health for more information. More details and worked examples can be found at** https://coventrycc.sharepoint.com/Info/Pages/What-is-an-Equality-Impact-Assessment-(EIA).aspx |

| Question | Issues to consider |
|---|---|
| 2.3a What HIs exist in relation to your work / plan / strategy | • Explore existing data sources on the distribution of health across different population groups *(examples of where to find data to be included in support materials)*<br>• Consider protected characteristics and different dimensions of HI such as socio-economic status or geographical deprivation |
| | Response:<br><br>There are strong correlations between single homelessness/rough sleeping and complex needs such as substance misuse and a multiplicity, and heightened severity, of both physical and mental health conditions. Research demonstrates that those who are homeless/rough sleeping: |

- 50 times more likely to have Hepatitis C
- 34 times more likely to have Tuberculosis 1
- 12 times more likely to have epilepsy
- 6 times more likely to have heart disease 2
- 9 times more likely to commit suicide

According to the Local Government Association (LGA) homelessness is a measure of our collective success, or otherwise, in reducing inequalities – (Local Government Association (2017) and Ill health can be both a cause and a consequence of homelessness – Public Health England (2019). In order to help people sustain stable accommodation, it has been suggested that more action is required to enable better integration of health and social care, and to help people access the healthcare services they require – NICE NG214 (2022). Unsatisfactory experiences following previous contacts with health services can lead to avoidance of further contact with NHS services and therefore people being less likely to receive healthcare despite high needs – NHS England (2023).

Core20PLUS5 is a national NHS England approach to support the reduction of healthcare inequalities at both national and local level. The core 20 PLUS5 groups identified for Coventry and Warwickshire are newly arrived and transient communities, including people who are homeless. They were identified because of the significant inequalities they experience including in healthcare access, experience and outcomes.

People who are homeless, rough sleeping or living in insecure housing typically experience multiple risk factors for poor health (such as poverty, violence, and complex trauma). They experience stigma and discrimination and are not consistently accounted for in records such as healthcare databases – variation in name spellings being one such reason, as does frequent changes or absences of an address. These experiences and factors frequently lead to barriers in access to healthcare and result in extremely poor health outcomes. Without appropriate access to primary and community care, and early / preventative interventions, people in inclusion health groups are likely to turn to acute services:

For instance, A&E attendance is 6-8 times higher for people experiencing homelessness and 28 times higher for people who experience both homelessness (rough sleeping) and alcohol dependency.

Despite inclusion health groups being disproportionally smaller in number than the general population, volume of attendance and consistently poor health outcomes lead to the cost of providing health and social care services (where required) being disproportionately higher. People experiencing homelessness

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often face some of the most significant health inequalities of all; with average life expectancy around 30 years lower than that of the general population.

Homeless people are more likely to die young, with an average age of death of 47 years old for men and even lower for homeless women at 43, compared to 77 for the general population, 74 for men and 80 for women.

Registration with a general practice is essential since general practitioner (GP) referrals are needed for most specialist treatment. The Anchor Centre is commissioned to provide a specialist service for people experiencing homelessness and the Meridian Centre for people with no recourse to public funds. However, many people experiencing homelessness are registered at other practices. The Anchor Centre accepts patients who have been rough sleeping, living in hostels, sofa surfing, or in temporary accommodation; around a third of the 610 patients have previously slept rough.

The city has a rough sleeping service that works proactively with people rough sleeping or at risk of rough sleeping, often supporting individuals with complex health needs to access medical interventions. Our commissioned homelessness support services have specific KPI measures around accessing health care and GP registration.

CWPT employ a homeless pathway Mental Health social worker who works closely with the rough sleeping team as well as supporting those living in temporary and supported accommodation to access support and MH interventions.

A palliative care team for those who are homeless has recently been established to support people at end of life. The vulnerable persons and complex needs forum provides a case management “team around the person “approach to supporting people at risk of homelessness due to MCN and health challenges.

Homelessness services have strong working relationships with both Adults health services and social care and with public health colleagues in terms of infectious diseases and health protection and until recently hosted an infectious disease outreach worker on behalf of the health protection function.

There has historically been a specific challenge around hospital discharge, as people were at times being discharged at night without statutory services being informed that they need accommodation. Homeless patients also have substantially higher rates of self-discharge from hospital, often linked to substance misuse. The creation of a homelessness pathway lead role at UHCW in December 2023 has already had a positive impact in terms of appropriate

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| | discharges and discharges for those who are homeless are being better coordinated and facilitated.<br><br>Homelessness services work closely with sexual health services (ISH) including support for testing and treatment when needed.<br><br>Research and local consultation have demonstrated that the following health service and patient led issues impact on the health of the cohort which may mean that they access secondary care services at a higher level of severity which may result in longer stays and early death.<br>• many homeless people do not see their health as important due to other pressing needs such as accessing a bed for the night, food, and drugs.<br>• healthcare services are generally highly structured and inflexible and rely on the individual contacting and going to the health care service, this may be more difficult for the cohort if they do not have a phone, or credit to use their phone and do not have the money to access the service<br>• chaotic lifestyles and or a cognitive behaviour deficit may mean they forget appointments and do not adhere to or complete treatment<br><br>The DoH (2010) research into the NHS costs of treating single people sleeping rough, the hidden homeless or living in a hostel concluded that the total cost of hospital usage by this cohort is conservatively estimated to be £85 million per annum. This is around 4 times the level of the general population, with inpatient costs (the bulk of the usage for this client group) being 8 times higher than for the comparison population (aged 16-64). These extra costs are thought to arise from the severity of their health conditions and because they are more likely to be admitted as emergency admissions.<br><br>Although single homeless people are more likely to suffer the detrimental health impacts from homelessness children and adults within families also have an increased risk of poor mental health. Research shows that long term stays in temporary accommodation, particularly shared accommodation, can have negative health impacts on families. |
| 2.3b How might your work affect HI | **Consider and answer below:** |

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| (positively or negatively).<br><br>How might your work address the needs of different groups that share protected characteristics | • Think about whether outcomes vary across groups and who benefits the most and least, for example, the outcome for a woman on a low income may be different to the outcome for a woman a high income<br>• Consider what the unintended consequences of your work might be |
| | Response:<br><br>Underpinning the identified themes in the new Strategy there will be 4 key principles one of which is Improving life chances and health outcomes.<br><br>By Recognising homelessness as part of a wider system of inequalities, we will seek to improve life chances and health outcomes, through our partnership approach to tackling homelessness and joining systems up. This will include;<br>• Raising awareness of the impact of homelessness on health and wellbeing outcomes, including how homelessness can exacerbate existing problems, issues and support needs, particularly in relation to mental health.<br>• Carry out specific initiatives around health and wellbeing for homeless households as well as ensuring our approach to preventing homelessness and supporting households into settled sustainable accommodation provides a basis upon which they can thrive.<br>• Working in partnership with all agencies and organisations responsible for health and care services when there is a risk of homelessness, or it is the presenting issue.<br><br>. |
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2.4 Next steps - What specific actions will you take to address the potential equality impacts and health inequalities identified above?

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| N/A |

## DIGITAL INCLUSION

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| **2.5** | The Covid-19 pandemic accelerated the uptake of digital services nationally, whereby people who are digitally enabled have better financial opportunities, can access new information and are better connected to others (Lloyds Consumer Digital Index, 2021). However, for those who are digitally excluded, the digital divide has grown during the last two years, and without intervention people will be left behind with poorer outcomes across employment, health and wellbeing, education and service access. Some people are more likely to be excluded including: older people, people from lower income households, unemployed people, people living in social housing, disabled people, school leavers before 16 with fewer educational qualifications, those living in rural areas, homeless people, or people who's first language is not English (NHS Digital.)<br><br>Some of the barriers to digital inclusion can include lack of:<br><br>• **Access** to a device and/or data<br>• **Digital skills**<br>• **Motivation** to get online<br>• **Trust** of online safety<br><br>Digital exclusion is not a fixed entity and may look different to different people at different times.<br><br>Example 1. Person A, has access to a smartphone and monthly data and can access social media apps, however lacks the digital skills and confidence, and appropriate device to create a CV, apply for jobs and attend remote interviews, and/or access educational and skills resources.<br><br>Example 2. Person B, is digitally confident and has their own laptop, however due a lower household income and other financial priorities, they cannot afford their monthly broadband subscription and can no longer get online to access the services they need to.<br><br>Example 3. Person C has very little digital experience and has heard negative stories on the news regarding online scams. Despite having the financial resource, they see no benefit of being online and look for alternatives whenever possible. A new council service requires mandatory online registration, therefore they do not access it.<br><br>It is important that we all consider how we can reduce digital inequalities across our services, and this may look very different depending on the nature of our work.<br><br>**Please answer the questions below to help identify if the area of work will have any impact on digital inequalities, positive or negative.** |

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| | **If you need assistance in completing this section please contact: Laura Waller (*Digital Services & Inclusion Lead, CCC*). More details and worked examples can be found at** https://coventrycc.sharepoint.com/Info/Pages/What-is-an-Equality-Impact-Assessment-(EIA).aspx |

| Question | Issues to consider |
|---|---|
| 2.5 What digital inequalities exist in relation to your work / plan / strategy? | • Does your work assume service users have digital access and skills?<br>• Do outcomes vary across groups, for example digitally excluded people benefit the least compared to those who have digital skills and access?<br>• Consider what the unintended consequences of your work might be. |
| | Response:<br><br>The Strategy has a focus on prevention and early intervention including ensuring our services are accessible to all. The strategy does not assume or require people to have digital skills or be able to access digital tools to benefit from any element. |
| 2.5b How will you mitigate against digital inequalities? | • If any digital inequalities are identified, how can you reduce these?<br>For e.g., if a new service requires online registration you may work with partner organisations to improve digital skills and ensure equitable processes are available if someone is unable to access online. |
| | Response:<br><br>We will work with partner organisations to reduce digital inequality and improve access to services |

2.6 How will you monitor and evaluate the effect of this work?

The strategy will have its own delivery plan, progress against the plan will be monitored by our own internal monitoring mechanisms as well as via regular reporting to the city's Homelessness Partnership Forum.

2.7 Will there be any potential impacts on Council staff from protected groups?

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| **No** |

You should only include the following data if this area of work will potentially have an impact on Council staff. This can be obtained from: Nicole.Powell@coventry.gov.uk

**Headcount:**

**Sex:**

| | |
|---|---|
| Female | |
| Male | |

**Age:**

| | |
|---|---|
| 16-24 | |
| 25-34 | |
| 35-44 | |
| 45-54 | |
| 55-64 | |
| 65+ | |

**Disability:**

| | |
|---|---|
| Disabled | |
| Not Disabled | |
| Prefer not to state | |
| Unknown | |

**Ethnicity:**

| | |
|---|---|
| White | |
| Black, Asian, Minority Ethnic | |
| Prefer not to state | |
| Unknown | |

**Religion:**

| | |
|---|---|
| Any other | |
| Buddhist | |
| Christian | |
| Hindu | |
| Jewish | |
| Muslim | |
| No religion | |
| Sikh | |
| Prefer not to state | |
| Unknown | |

**Sexual Orientation:**

| | |
|---|---|
| Heterosexual | |
| LGBT+ | |
| Prefer not to state | |
| Unknown | |

3.0 Completion Statement

**As the appropriate Head of Service for this area, I confirm that the potential equality impact is as follows:**

No impact has been identified for one or more protected groups ☐

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|---|
| Positive impact has been identified for one or more protected groups x |
| Negative impact has been identified for one or more protected groups ☐ |
| Both positive and negative impact has been identified for one or more protected groups ☐ |

4.0 Approval

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| **Signed: Head of Service:**<br><br>**Jim Crawshaw** | **Date: 23/07/24** |
| **Name of Director:**<br><br>**Pete Fahy** | **Date sent to Director:**<br><br>**23/7/24** |
| **Name of Lead Elected Member:**<br><br>**David Welsh** | **Date sent to Councillor:**<br><br>**26/7/24** |

**Email completed EIA to** equality@coventry.gov.uk